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July 2, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2249–P2
P.O. Box 8016
Baltimore, MD 21244–8016

Re: CMS–2249–P2: Proposed Rule: Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice

Dear Ms. Tavenner:

The Commonwealth of Massachusetts appreciates the opportunity to submit comments regarding the Proposed Rule: Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice.

The Commonwealth has comments on the following sections of the proposed rule:

1. Section II. B. 6. Independent Assessment. This section indicates:

   - that "universal core elements" of assessments are being developed under the Balancing Incentives Program, which would apply to 1915(i) and (k) and possibly to other programs. Since this approach to assessments may also apply to 1915(c) HCBS waiver programs, it is important to understand what the universal core elements will be. Depending on what these elements address, states will want to understand very clearly whether they are appropriate, realistic, and relevant to waiver populations prior to applying such assessment elements to waiver participants.
   - in addition, passing reference is made to "independent assessment" but the term is not precisely defined. It is unclear whether the proposed

regulation would require those conducting assessments to be conflict free as defined in the Balancing Incentives Program.

2. Section II. B. 7. Person-Centered Service Plan. This section indicates:

   - that the Service Plan "must be signed by all individuals and providers responsible for its implementation." This is impractical for a number of reasons, chiefly that service plans change often and appropriately, when member needs change and/or are revised at least annually. To require "all individuals and providers" to sign the service plan whenever the plan is initiated or changed will, in practice, make the process untenable.
   - that a copy of the Person-Centered Service Plan be given to all providers who provide services to the participant. While Massachusetts agrees that the *relevant portion* of the service plan should be provided to each provider serving the member, to give all providers the entire service plan would be to share personal health information of the member to providers who do not necessarily need to see the entire plan.
   - that Person-Centered Service Plans should "reflect goals related to community living, to the extent that Medicaid state plan services would be available to support such goals." Massachusetts agrees that setting expectations in a manner that conveys realistic goals for service planning is appropriate.
   - that the Person-Centered Planning process will be driven by the member and
     - "Include people chosen by the individual;
     - Provide necessary support to ensure that the individual has a meaningful role in directing the process to the maximum extent possible, and is enabled to make informed choices and decisions;
     - Is timely and occurs at times and locations of convenience to the individual;
     - Reflects cultural considerations of the individual;
     - Include strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants;
     - Offers choices to the individual regarding the services and supports they receive and from whom.
     - Includes a method for the individual to request updates to the plan.
     - Records the alternative home and community-based settings that were considered by the individual."

   Massachusetts believes the listed considerations present a thoughtful approach to service planning consistent with person centered planning process requirements the state has embraced in 1915(c) waivers and other initiatives such as the Duals Demonstration.

3. Section II. B. 10. Conflict of Interest. This section:

   - requires the state to establish conflict of interest standards for independent evaluation, independent assessment and person-centered service plan development. It does allow that "in certain circumstances," states may develop firewall policies. Massachusetts agrees it is important to maintain the person-centered focus of service planning, free from incentives for self-referral. As noted, in some circumstances it is not feasible to completely separate service planning and service provision and the development of firewall policies is an appropriate safeguard.

4. Section II. E. 2. HCBS Provided in the Community, Not in Institutions. This section:

   - describes settings similarly to MFP qualified housing, but focuses more clearly on the characteristics of the setting and does not explicitly limit group homes to four or fewer individuals. Massachusetts believes this will afford states needed flexibility to utilize group homes serving up to 5 people.
   - addresses that members must have control over their home/environment, but also makes allowances for serving people with cognitive disabilities – again, providing appropriate flexibility to ensure that individuals can remain in the community for as long as possible.
   - describes a possible criterion for which CMS seeks comment that would require that "receipt of any particular service or support can not be a condition for living in the unit." Massachusetts agrees this is important in settings, such as an individual's home or apartment. However, such a criterion should not apply to settings such as group homes or assisted living residences, where the provision of services is inherent in the setting.
   - includes flexibility to allow housing on the grounds of a public institution. This would give states additional options, as long as such settings have community characteristics and do not isolate residents from community involvement. Massachusetts agrees that this provision is another appropriate measure to provide useful flexibility, allowing states to support members to live outside the more traditional institutional setting.
   - allows states to continue HCBS state plan services to members during short hospital stays, for "physical needs over and above such services available in a hospital." This is a welcome concept as the provision will be especially beneficial for HCBS continuity. It will benefit both the member, who will be able to maintain what may be a long-standing connection to caregivers, and providers/caregivers who will be able to continue services to the member without disruption of their employment. Massachusetts has received extensive stakeholder feedback indicating that Personal Care Attendants should be able to maintain employment during a member's hospitalization so as to appropriately preserve the member's needed services and avoid disruption of on-going community based

services. When a member is in the hospital, and therefore loses his/her PCA, it often leads to extended stays or transfer to a nursing facility until and unless the member can find a new PCA.

5. Section II. G. 4. Prohibition on Payment Reassignment, Individual Practitioner Workforce and Development Concerns. This section:
   - Provides that a state could claim as a provider payment amounts that are not directly paid to the provider, but are withheld and paid on behalf of the provider, such as health and welfare benefit contributions. Massachusetts supports this proposed rule but seeks clarification as to what would constitute a health and welfare benefit contribution. Specifically, Massachusetts would like to know if this would include amounts for paid time off for personal care attendants.

We look forward to working with you as we continue to implement the provisions of the Affordable Care Act in Massachusetts and move towards a nationwide system of more affordable and comprehensive health insurance for all.

Sincerely,

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Medicaid Director